

Texas Medical Board Press Release

FOR IMMEDIATE RELEASE

March 22, 2016

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TMB disciplines 62 physicians at March meeting

At its March 4, 2016 meeting, the Texas Medical Board disciplined 62 licensed physicians and issued seven cease and desist orders. The disciplinary actions included: twelve orders related to quality of care violations, five orders related to unprofessional conduct, five revocations, nine voluntary surrenders, two restrictions, three suspensions, two orders related to other states' actions, five orders related to peer review actions, one order related to criminal activity, six orders related to nontherapeutic prescribing, two orders related to improper prescribing, one order related to failure to properly supervise or delegate, one order related to violation of Board rules, five orders related to violation of prior Board order, and three orders related to inadequate medical records. The Board also took an action against a Non-Certified Radiologic Technician.

The Board issued 215 physician licenses at the March meeting, bringing the total number of physician licenses issued in FY16 to 1,619.

No rules were adopted during the March meeting.

DISCIPLINARY ACTIONS

QUALITY OF CARE

Altamirano, Ray, M.D., Lic. No. P0535, San Antonio

On March 4, 2016, the Board and Ray Altamirano, M.D., entered into an Agreed Order requiring Dr. Altamirano to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in drug seeking behavior and eight hours in risk management; within 60 days submit a written pain management contract to the Compliance Division of the Board for review and approval; and within 60 days pay an administrative penalty of \$1,500. The Board found the need for a strict control of Dr. Altamirano's patients being treated under a pain management protocol. Dr. Altamirano failed to meet the standard of care by not following up on and documenting all laboratory studies ordered.

Elhage, Izzeldeen B., M.D., Lic. No. N8002, Houston

On March 4, 2016, the Board and Izzeldeen B. Elhage, M.D., entered into an Agreed Order requiring Dr. Elhage to limit his practice to his current setting of in-patient psychiatry; within one year complete at least eight hours of CME in risk management; shall not be permitted to supervise or delegate prescriptive authority to a physician assistant or advanced practice nurse or supervise a surgical assistant; and pay an administrative penalty of \$3,000 within 90 days. The Board found Dr. Elhage failed to destroy, or document the destruction of, his prescription pad, and failed to turn his prescription pads over to the Department of Public Safety; failed to report possible fraudulent prescriptions to DPS and DEA after receiving notice and failed to exercise adequate control over his prescription pads.

Gomez, Jaime Rafael, M.D., Lic. No. H9957, El Paso

On March 4, 2016, the Board and Jaime Rafael Gomez, M.D., entered into an Agreed Order requiring Dr. Gomez to within one year complete at least eight hours of CME, divided as follows: four hours in risk management and four hours in professional communications. The Board found Dr. Gomez failed to use proper diligence in his professional practice by not communicating with the referring gastroenterologist regarding the lack of findings on the endoscopic procedure.

Hill, Barry Trent, M.D., Lic. No. N9066, San Antonio

On March 4, 2016, the Board and Barry Trent Hill, M.D., entered into an Agreed Order requiring Dr. Hill to within one year complete at least 24 hours of CME, divided as follows: eight hours in medical recordkeeping, eight hours in risk management and eight hours in treatment and care of post-surgical complications. The Board found Dr. Hill failed to meet the standard of care by not acquiring a patient's baseline labs from the patient's previous hospital, which would have indicated an abnormal lab creatinine value.

Jakubowski, Robert G., M.D., Lic. No. G9479, San Antonio

On March 4, 2016, the Board and Robert G. Jakubowski, M.D., entered into an Agreed Order requiring Dr. Jakubowski to within one year complete at least 16 hours of CME, divided as follows: eight hours of in risk management and eight hours in medical recordkeeping; and within 90 days submit a written protocol related to monitoring, tracking, and reviewing diagnostic tests, and related office procedures and processes to the Compliance Division of the Board for approval. The Board found Dr. Jakubowski delayed in following up on whether an ordered x-ray was obtained and/or following up on the results of the x-ray on one patient. Dr. Jakubowski did not look at the medical records from the previous visit when he provided treatment to the patient after the x-ray was ordered.

Kaufman, James Kevin, M.D., Lic. No. L0318, Fort Worth

On March 4, 2016, the Board and James Kevin Kaufman, M.D., entered into an Agreed Order requiring Dr. Kaufman to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in risk management and eight hours in medical recordkeeping; and within 60 days pay an administrative penalty of \$3,000. The Board found Dr. Kaufman performed a wrong level surgery and kept inadequate medical records for one patient; and maintained inadequate records for another patient.

Long, Joseph Merl, M.D., Lic. No. E0095, Victoria

On March 4, 2016, the Board and Joseph Merl Long, M.D., entered into an Agreed Order requiring Dr. Long to within one year complete at least 16 hours of CME, divided as follows: eight hours in physician-patient communication and eight hours in risk management. The Board found Dr. Long did not provide an adequate history in his progress notes and his documented treatment plan lacked appropriate evaluation and follow-up. Dr. Long did not attempt to obtain prior records on the patient or order sufficient lab tests that were indicated and failed to offer the patient Barium swallow or other less expensive radiographic options.

Obasi, Patrick Chidi, M.D., Lic. No. N6542, Rancho Cucamonga, CA

On March 4, 2016, the Board and Patrick Chidi Obasi, M.D., entered into an Agreed Order requiring Dr. Obasi to within one year complete at least 12 hours of CME, divided as follows: four hours in risk management and eight hours of patient assessment with a focus on liver failure/liver disease. The Board found Dr. Obasi failed to obtain appropriate pre-operative studies to fully evaluate a patient's risk prior to performing surgery.

Port, John Teig, M.D., Lic. No. K9393, Mesquite

On March 4, 2016, the Board and John Teig Port, M.D., entered into an Agreed Order requiring Dr. Port to within one year complete at least 48 hours of CME, divided as follows: eight hours in medical ethics, eight hours in risk management, eight hours in physician-patient communication and eight hours in orthopedic surgical complications; and pay an administrative penalty of \$2,500 within 60 days. The Board found Dr. Port failed to meet the standard of care by failing to fully disclose or properly document the use of a third screw used to achieve graft fixation, failed to properly supervise a delegate by not reviewing a postoperative x-ray that was inappropriately documented normal by a physician assistant but later discovered to be abnormal, and recurring health care liability claims resulting in remuneration.

Wheeler, James Charles, M.D., Lic. No. J6277, Bedford

On March 4, 2016, the Board and James Charles Wheeler, M.D. entered into an Agreed Order requiring Dr. Wheeler to within one year complete at least 12 hours of CME, divided as follows: eight hours in risk management and four hours in pediatric neurology; and within 60 days pay an administrative penalty of \$1,500. The Board found Dr. Wheeler failed to measure a patient's head at the two-year well child visit in October of 2012. Dr. Wheeler did not refer the patient to a neurologist despite the patient's symptoms of hydrocephalus, including ongoing signs of developmental delays and occasions of vomiting.

Whisenant, Stanley Wayne, M.D., Lic. No. J7725, Rowlett

On March 4, 2016, the Board and Stanley Wayne Whisenant, M.D., entered into a Mediated Agreed Order requiring Dr. Whisenant to within one year complete at least 12 hours of CME, divided as follows: four hours in risk management, four hours in diagnosis and therapy of cervical spine diseases and four hours in physician-patient communications. The Board found Dr. Whisenant failed to maintain adequate medical records, failed to meet the standard of care by failing to utilize fluoroscopy or other acceptable form of guidance in performing a procedure and by failing to adequately document his conversation with the patient regarding her decision not to use fluoroscopy in the procedure.

Zaheer, Syed Javeed, M.D., Lic. No. L2065, Livingston

On March 4, 2016, the Board and Syed Javeed Zaheer, M.D., entered into an Agreed Order requiring Dr. Zaheer to within 30 days schedule an assessment with the Texas A&M Health Science Center Knowledge, Skills, Training, Assessment, and Research (KSTAR) program; have his practice monitored by another physician for 12 consecutive monitoring cycles; and within one year complete at least 36 hours of CME, divided as follows: 24 hours in emergency medicine and 12 hours in critical care. The Board found Dr. Zaheer breached the standard of care in failing to admit a patient to the hospital based on the patient's clinical presentation in which the patient met both the systemic inflammatory response syndrome (SIRS) criteria and sepsis criteria. Dr. Zaheer also failed to order myoglobin or CPK lab tests to address the possibility of potential rhabdomyolysis.

UNPROFESSIONAL CONDUCT

Banjo, Abimbola Michael, M.D., Lic. No. J9620, Pleasanton

On March 4, 2016, the Board and Abimbola Michael Banjo, M.D., entered into an Agreed Order requiring Dr. Banjo to within one year complete at least eight hours of CME in risk management; and within 60 days pay an administrative penalty of \$1,500. The Board found Dr. Banjo failed to sign a patient's electronic death certificate within 5 days of receiving the notice from the funeral home.

Ethridge, Richard, M.D., Lic. No. M5152, Fort Worth

On March 4, 2016, the Board and Richard Ethridge, M.D., entered into an Agreed Order requiring Dr. Ethridge to have a chaperone present during physical examinations on female patients; within 60 days pay an administrative penalty of \$2,500; within 30 days undergo an independent medical evaluation and follow all recommendations for care and treatment; within one year complete the professional boundaries course offered by University of California San Diego Physician Assessment and Clinical Education (PACE) program; and within one year complete at least eight hours of CME in ethics. The Board found Dr. Ethridge admitted to engaging in inappropriate sexual contact with a patient from 2011 through 2012, admitted to engaging in inappropriate sexual communications via email with a patient in 2011 and admitted to signing his wife's signature without her knowledge or consent on a settlement document related to his inappropriate sexual relationship with a patient.

Pollack, Jo, M.D., Lic. No. J6665, Houston

On March 4, 2016, the Board and Jo Pollack, M.D., entered into an Agreed Order requiring Dr. Pollack to within one year complete at least four hours of CME in ethics. The Board found Dr. Pollack exhibited unprofessional conduct by prescribing to a person with whom Dr. Pollack had a close professional and personal friendship and kept no medical records for the patient.

Russell, Carl Lindsey, M.D., Lic. No. L3808, Dallas

On March 4, 2016, the Board and Carl Lindsey Russell, M.D., entered into an Agreed Order requiring Dr. Russell to within one year complete at least eight hours of CME, divided as follows: four hours in physician to physician professional communications and four hours in physician patient communication. The Board found Dr. Russell was unprofessional in his interactions with an ER physician after the ER physician called Dr. Russell and requested that he take the patient back to the original facility for acute care after Dr. Russell transferred the patient to a long-term care facility for palliative care where the patient was again transferred to an emergency care department in a hospital.

Thaker, Anil P., M.D., Lic. No. M4586, Houston

On March 4, 2016, the Board and Anil P. Thaker, M.D., entered into an Agreed Order publicly reprimanding Dr. Thaker and requiring him to undergo an independent medical evaluation within 30 days; within one year complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year and three attempts pass the Medical Jurisprudence Exam; and within one year complete at least four hours of CME in ethics. The Board found Dr. Thaker committed unprofessional conduct due to a boundaries violation with one patient. Dr. Thaker called a patient to relay results of her laboratory test. A conversation ensued in which Dr. Thaker claimed the patient invited him to her home and he accepted the invitation. Dr. Thaker went to the patient's home and they sat on her couch and talked and later kissed and hugged each other.

REVOCAATION

Carrillo, Eduardo, M.D., Lic. No. L2172, Edinburg

On March 4, 2016, the Board and Eduardo Carrillo, M.D., entered into an Agreed Order of Revocation in which Dr. Carrillo agreed to the revocation of his Texas medical license in lieu of further disciplinary proceedings. Dr. Carrillo pled guilty to Aggravated Identity Theft relating to illegal remunerations involving Federal health care programs, a Class E felony, and Health Care Fraud, a Class D felony.

Fino, Sameer Andoni, M.D., Lic. No. J2004, Dallas

On March 4, 2016, the Board and Sameer Andoni Fino, M.D., entered into an Agreed Order of Revocation in which Dr. Fino agreed to the revocation of his Texas medical license in lieu of further disciplinary proceedings. Dr. Fino pled guilty to a felony charge related to the dispensing of controlled substances.

Hall, Rahn Garner, M.D., Lic. No. G2981, Houston

On March 4, 2016, the Board and Rahn Garner Hall, M.D., entered into an Agreed Order of Revocation in which Dr. Hall agreed to the revocation of his Texas medical license in lieu of further disciplinary proceedings. Dr. Hall was under investigation by the Board for allegations of nontherapeutic prescribing and illegal operation of a pain management clinic. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

Le, Dung Hoang Guoc, M.D., Permit No. BP100050501, Watauga

On March 4, 2016, the Board entered a Default Order against Dung Hoang Quoc Le, M.D., which revoked his Texas physician in training permit. On August 25, 2015, the Board filed a Complaint with the State Office of Administrative Hearings (SOAH) in Docket No. 503-15-5516.MD, alleging Dr. Le was terminated from his residency program following an arrest and felony theft charge. Dr. Le was served notice of the Complaint and subsequent hearing at SOAH. Dr. Le failed to appear at the SOAH hearing and no answer or responsive pleading was ever filed by Dr. Le. The board granted a Determination of Default and Dr. Le's physician in training permit was revoked by Default Order. This order resolves a formal complaint filed at SOAH. Dr. Le has 20 days from the service of the order to file a motion for rehearing.

McClellan, David Mark, Lic. No. G0476, Crosby

On March 10, 2016, the Board entered a Final Order against David Mark McClellan, M.D., which revoked Dr. McClellan's Texas medical license. The Board found Dr. McClellan failed to maintain adequate medical records and failed to follow Board rules related to pain management. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. McClellan has 20 days from the service of the order to file a motion for rehearing.

VOLUNTARY SURRENDER

Alvarez, Victor Raul, M.D., Lic. No. D4010, Denton

On March 4, 2016, the Board and Victor Raul Alvarez, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Alvarez agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board alleged Dr. Alvarez had violated terms of a Remedial Plan.

Evans, Richard Arthur, M.D., Lic. No. E3816, Houston

On March 4, 2016, the Board and Richard Arthur Evans, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Evans agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The order is effective on June 1, 2016, to allow Dr. Evans to wind down his practice and ensure proper transfer of care for his patients to another physician. The Board found Dr. Evans has a medical condition which may affect his ability to practice medicine. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

Hadad, Anibal Raul, M.D., Lic. No. H1098, Houston

On March 4, 2016, the Board and Anibal Raul Hadad, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Hadad agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Hadad was under investigation by the Board regarding allegations that he failed to meet the standard of care in his treatment of two patients.

Kelly, Michael V., II, M.D., Lic. No. D8302, Houston

On March 4, 2016, the Board and Michael V. Kelly, II, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Kelly agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Kelly was under investigation by the Board for allegations related to nontherapeutic prescribing of a topical cream. Dr. Kelly has indicated that he has retired from the active practice of medicine and wishes to surrender his license.

Kunynetz, Rodion Andrew, M.D., Lic. No. F5262, Ontario, Canada

On March 4, 2016, the Board and Rodion Andrew Kunynetz, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Kunynetz agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Kunynetz was under investigation by the Board due to Dr. Kunynetz being the subject of a disciplinary action by the College of Physicians and Surgeons of Ontario.

Lavake, Thomas E., M.D., Lic. No. D3311, Arlington

On March 4, 2016, the Board and Thomas E. Lavake, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Lavake agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board found that Dr. Lavake prescribed pain and sedative medications in a non-therapeutic manner for several patients.

Lugo-Faria, Merlin D., M.D., Lic. No. E3055, Houston

On March 4, 2016, the Board and Merlin D. Lugo-Faria, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Lugo-Faria agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board had initiated an investigation of Dr. Lugo-Faria's ability to continue in the practice of medicine due to a medical condition.

McColskey, Christopher, M.D., Permit No. BP10042955, Houston

On March 4, 2016, the Board and Christopher McColskey, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. McColskey agreed to voluntarily surrender his Texas physician in training permit in lieu of further disciplinary proceedings. Dr. McColskey was under investigation by the Board following his resignation from the anesthesiology residency program at The University of Texas Medical School at Houston following the facility's concerns regarding possible abuse of controlled substances. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

Moloney, Michael Eugene, M.D., Lic. No. F6189, Windthorst

On March 4, 2016, the Board and Michael Eugene Moloney, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Moloney agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board had alleged Dr. Moloney failed to obtain and/or document the required CME credits. Dr. Moloney indicated to the Board that he no longer practices in Texas.

RESTRICTION

Easter, Thomas G., II, M.D., Lic. No. G7801, El Paso

On March 10, 2016, the Board entered a Final Order against Thomas G. Easter, II, M.D., publicly reprimanding Dr. Easter and requiring Dr. Easter to have his DEA/DPS controlled substances registration certificate modified to eliminate Schedules II and III; have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least eight hours of CME in risk management; and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Easter engaged in inappropriate prescribing of controlled substances and that Dr. Easter failed to provide medical records to Board staff within a reasonable amount of time. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Easter has 20 days from the service of the order to file a motion for rehearing.

Hawkins, Willie James, M.D., Lic. No. G2147, Missouri City

On March 10, 2016, the Board entered a Final Order against Willie James Hawkins, M.D., placing Dr. Hawkins' Texas medical license on a probated suspension and restricting his practice to administrative medicine for a minimum of five years. While on probation, Dr. Hawkins may not supervise or delegate prescriptive authority to any midlevels. In the event after five years the restriction is modified, Dr. Hawkins shall not be permitted to engage in the treatment of chronic pain, prescribe controlled substances nor reapply for permission from the DEA/DPS to prescribe controlled substances. On November 23, 2015, the District Court of Travis County, Texas, issued a judgment and remanded the Final Order of Revocation issued by the Board dated November 7, 2014, for further proceedings by the Board consistent with the judgment with sanctions citing to the aggravating factors.

SUSPENSION

Boyd, George Borland, III, D.O., Lic. No. M9876, San Antonio

On March 4, 2016, the Board and George Borland Boyd, III, D.O., entered into an Agreed Order of Suspension, suspending Dr. Boyd's Texas medical license until such a time as he requests in writing to have the suspension stayed or lifted, and personally appears before the Board and provides evidence that he is physically, mentally, and otherwise competent to safely practice medicine. The Board found Dr. Boyd suffers from a mental or physical condition that prevents him from practicing medicine with reasonable skill and safety to patients.

Psyk, Andrew Michael, M.D., Lic. No. L1171, Houston

On March 4, 2016, the Board and Andrew Michael Psyk, M.D., entered into an Agreed Order of Suspension, suspending Dr. Psyk's medical license until such a time as he requests in writing to have the suspension stayed or lifted, and personally appears before the Board and provides evidence that he is physically, mentally, and otherwise competent to safely practice medicine. The Board found Dr. Psyk had violated his Physician Health Program agreement by missing drug screens, failing to cooperate with PHP staff, having a positive drug screen, and Dr. Psyk's admission that he had relapsed.

Ryan, Robert Patton, M.D., Lic. No. E6901, Hondo

On March 4, 2016, the Board and Robert Patton Ryan, M.D., entered into an Agreed Order of Suspension, suspending Dr. Ryan's Texas medical license until such a time as he requests in writing to have the suspension stayed or lifted, and personally appears before the Board and provides evidence that he is physically, mentally, and otherwise competent to safely practice medicine; within one year complete an independent medical evaluation and follow all recommendations for care and treatment. The Board found Dr. Ryan is unable to practice with reasonable skill and safety to patients because of an illness or as a result of any mental or physical condition.

OTHER STATES' ACTIONS

Recine, Carl Albert, M.D., Lic. No. Q4833, Dallas

On March 4, 2016, the Board and Carl Albert Recine, M.D., entered into an Agreed Order publicly reprimanding Dr. Recine. The Board found Dr. Recine was issued a letter of admonition by the Colorado Board of Medical Examiners related to Dr. Recine's failure to properly diagnose a patient. Similar disciplinary action was taken by seven other state boards for the same issue.

Smith, Phillip Dean, M.D., Lic. No. Q1024, Lakewood, CO

On March 4, 2016, the Board and Phillip Dean Smith, M.D., entered into an Agreed Order requiring Dr. Smith to complete and comply with all terms as required by the Agreement with the Colorado Medical Board. Dr. Smith shall not practice in Texas until he requests permission in writing to resume practice, and personally appears before the Board and provides evidence that he is physically, mentally, and otherwise competent to safely practice medicine. The Board found Dr. Smith was the subject of disciplinary action by the Colorado Medical Board as a result of an arrest in New Mexico on the charges of possession of a controlled substance, possession of drug paraphernalia and driving while under the influence of liquor and/or drugs.

PEER REVIEW ACTIONS

Garcia, Anthony Fabro, M.D., Lic. No. N9858, Houston

On March 4, 2016, the Board and Anthony Fabro Garcia, M.D., entered into a Mediated Agreed order requiring Dr. Garcia to within one year and three attempts pass the Medical Jurisprudence Exam; within 120 days undergo an independent medical evaluation and follow all recommendations for care and treatment; within one year complete at least eight hours of CME in risk management; and Dr. Garcia shall not work more than 60 hours per week unless authorized by a treating psychiatrist for a period of six months. The Board found Dr. Garcia had his privileges at Triumph North Houston Hospital terminated based on an incident in which Dr. Garcia displayed erratic and delusional behavior and damaged hospital property. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

Pruitt, Charles Barton, D.O., Lic. No. K3403, Winnsboro

On March 4, 2016, the Board and Charles Barton Pruitt, D.O., entered into an Agreed Order requiring Dr. Pruitt to within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours in risk management. The Board found Dr. Pruitt was subject to peer review action at Trinity Mother Francis hospital and was asked to resign his privileges, which he did. The peer review action was based on standard of care issues related to inadequacies in Dr. Pruitt's documentation.

Schultz, F. Michael, M.D., Lic. No. D9736, Brownwood

On March 4, 2016, the Board and F. Michael Schultz, M.D., entered into an Agreed Order prohibiting Dr. Schultz from practicing obstetrics; requiring Dr. Schultz to have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete at least eight hours of CME in medical recordkeeping and four hours in ethics; and pay an administrative penalty of \$6,000 within 90 days. The Board found Dr. Schultz did not notify the Board of a peer review action in which Dr. Schultz resigned his privileges. Dr. Schultz violated the standard of care and engaged in nontherapeutic prescribing in that he had a pattern of availability issues, coverage issues, and inadequate documentation.

Timmons, Andrew Lansing, M.D., Permit No. BP10050982, Dallas

On March 4, 2016, the Board and Andrew Lansing Timmons, M.D., entered into an Agreed Order requiring Dr. Timmons to within 30 days submit to an evaluation by the Physician Health Program and comply with any and all recommendations; shall not be permitted to supervise or delegate prescriptive authority to midlevels. The Board found Dr. Timmons was terminated from his residency program for substance abuse which rendered him unable to safely practice medicine.

Wang, Fan, M.D., Lic. No. M2236, Houston

On March 4, 2016, the Board and Fan Wang, M.D., entered into an Agreed Order requiring Dr. Wang to within one year complete at least 16 hours of CME, divided as follows: eight hours in high-risk obstetrics, focusing on treatment of patients with HIV and eight hours in high risk management; and within 60 days pay an administrative penalty of \$3,000. The Board found Dr. Wang was subject to peer review disciplinary action that suspended his privileges. Dr. Wang later resigned. The peer review action was based on Dr. Wang not including the HIV status of a patient in the medical record and did not timely attend to the patient's signs of active labor.

CRIMINAL ACTIVITY**Alroumoh, Manaf, M.D., Lic. No. M9796, Houston**

On March 4, 2016, the Board and Manaf Alroumoh, M.D., entered into an Agreed Order publicly reprimanding Dr. Alroumoh and requiring him to complete all terms and conditions of the Pretrial Diversion Contract entered on August 4, 2015; within one year complete at least four hours of CME in anger management; and within 60 days pay a \$2,000 administrative penalty. The Board found Dr. Alroumoh was involved in an altercation with a family member on September 16, 2014 and was arrested for criminal assault by the Sugar Land Police Department.

NONTHERAPEUTIC PRESCRIBING**Alnajjar, Mohammed R., M.D., Lic. No. K9981, El Paso**

On March 4, 2016, the Board and Mohammed R. Alnajjar, M.D., entered into an Agreed Order on Formal Filing requiring Dr. Alnajjar have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete the physician prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and within 60 days provide to the Board's Compliance Division a copy of Dr. Alnajjar's manual detailing the policies and procedures at his medical practice. The Board found Dr. Alnajjar's medical records for patients did not consistently and adequately document complete histories, examinations, follow-up examinations and treatment rationales. The medical records did not consistently include objective measures to ascertain whether the continued prescribing of medications to the patients were having a therapeutic benefit to the patients. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

Barroga, Deno Baltazar, M.D., Lic. No. M1495, Dallas

On March 4, 2016, the Board and Deno Baltazar Barroga, M.D., entered into an Agreed Order requiring Dr. Barroga to have his practice monitored by another physician for 12 consecutive monitoring cycles; within 180 days complete the Physician Prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year complete at least 12 hours of CME, divided as follows: four hours in medical recordkeeping and eight hours in pharmacology; and within 90 days pay an administrative penalty of \$3,000. The Board found Dr. Barroga nontherapeutically prescribed controlled substances and other medications to multiple patients.

Diaz, Ismael, Jr., M.D., Lic. No. L3952, Humble

On March 4, 2016, the Board and Ismael Diaz, Jr., M.D., entered into an Agreed Order publicly reprimanding Dr. Diaz and requiring Dr. Diaz to have his practice monitored by another physician for 12 consecutive monitoring cycles; within 180 days complete the Physician Prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; maintain a logbook of all prescriptions written for schedule II controlled substances; shall not, by telephone or other electronic means to a pharmacy, prescribe or refill a prescription for schedule II controlled substances, and Dr. Diaz shall not permit any individual under his supervision or control to facilitate such a prescription or refill to a pharmacy, other than by written prescription; shall not prescribe for longer than 30 days any schedule II controlled substance, or order any refill of such a prescription without requiring or conducting a patient visit; shall not order or refill any schedule III-V controlled substance without requiring or conducting a patient visit; within one year complete at least 16 hours of CME, divided as follows: eight hours in palliative care and eight hours in risk management; shall not be permitted to supervise or delegate prescriptive authority to midlevels; and pay an administrative penalty of \$8,000 within six months. The Board found Dr. Diaz, as medical director, routinely issued pre-signed blank prescriptions for controlled substances to hospice patients, failed to document

assessments and evaluations of patients, and prescribed high doses of opioids to many patients, many of whom did not demonstrate medical need for such drugs.

Giacona, Jewel Annette, M.D., Lic. No. H8073, Baytown

On March 4, 2016, the Board and Jewel Annette Giacona, M.D., entered into an Agreed Order prohibiting Dr. Giacona from treating patients for chronic pain or engaging in the practice of pain management; and requiring Dr. Giacona to within 30 days contact the Texas A&M Health Science Center Knowledge, Skills, Training, Assessment, and Research (KSTAR) program to schedule an assessment; have her practice monitored by another physician for 12 consecutive monitoring cycles; and within one year complete at least eight hours in medical recordkeeping. The Board found Dr. Giacona failed to meet the standard of care for chronic pain treatment, which included nontherapeutically prescribing large amounts of narcotic and sedative medications and failed to keep adequate medical records for several patients.

Spinks, David Wayne, D.O., Lic. No. F4557, Pasadena

On March 4, 2016, the Board and David Wayne Spinks, D.O., entered into an Agreed Order on Formal Filing requiring Dr. Spinks to within one year complete the Knowledge, Skills, Training, Assessment, and Research (KSTAR) program; have his practice monitored by another physician for eight consecutive monitoring cycles; within seven days request modification of his DEA/DPS controlled substances registration certificate to eliminate Schedule II and shall not reregister or otherwise obtain Controlled Substances Registrations for Schedule II without authorization from the Board; within one year and three attempts pass the Medical Jurisprudence Exam; and within one year complete at least 40 hours of CME, divided as follows: eight hours in medical recordkeeping, eight hours in weight loss management, four hours in risk management, four hours in treating anemia, eight hours in cardiovascular disease and eight hours in pain management. The Board found Dr. Spinks failed to monitor chronic pain patients for abuse or diversion of controlled substances, prescribed hydrocodone to two patients who were allergic to codeine, provided early refills without justification, failed to maintain adequate medical records in his treatment of hypertensive patients and provided false or misleading information to the Board. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

Venegas, Carlos, M.D., Lic. No. K0566, Dallas

On March 4, 2016, the Board and Carlos Venegas, M.D., entered into an Agreed Order requiring Dr. Venegas to within 7 days request to have his DEA/DPS controlled substances registration to eliminate Schedules II and III, and Dr. Venegas is limited to Schedules IV and V for dosages of 30 days and may not be re-filled without a patient visit; within one year complete the Knowledge, Skills, Training, Assessment, and Research (KSTAR) program; have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete 32 hours of CME, divided as follows: eight hours in pharmacology, eight hours in prescribing, eight hours in medical recordkeeping and eight hours in risk management; and pay an administrative penalty of \$10,000 within one year. The Board found Dr. Venegas' practice, prescribing, and documentation fell below the standard of care. Dr. Venegas nontherapeutically prescribed controlled substances to multiple patients, and failed to adequately supervise his midlevel providers.

IMPROPER PRESCRIBING

Buckner, Mark Brian, M.D., Lic. No. J1898, Sherman

On March 4, 2016, the Board and Mark Brian Buckner, M.D., entered into an Agreed Order prohibiting Dr. Buckner from treating or otherwise serving as a physician for his immediate family, and shall not prescribe, dispense, administer, or authorize any medications, including but not limited to controlled substances or dangerous drugs with addictive potential or potential for abuse, to himself or his immediate family; requiring Dr. Buckner to within one year and three attempts pass the Medical Jurisprudence Exam; and within 180 days complete the physician prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board found Dr. Buckner and his midlevel prescribed controlled substances to employees and family members without properly documenting an evaluation or justification to support the prescriptions. Dr. Buckner admits he was naïve and was not aware of the requirements for prescriptive delegation or the limitations on prescribing to family and persons with whom he has a close relationship.

Rozenboom, Morgen Melinda, M.D. Lic. No. K2115, Canton

On March 4, 2016, the Board and Morgen Melinda Rozenboom, M.D., entered into an Agreed Order requiring Dr. Rozenboom to within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours in prescribing to geriatric patients; and within one year and three attempts pass the Medical Jurisprudence Exam. The Board found Dr. Rozenboom prescribed controlled substances for a family member without demonstration of immediate need and for longer than 72 hours; failed to use proper diligence and to establish proper physician-patient relationship and did not adequately document the care for her family member.

FAILURE TO PROPERLY SUPERVISE OR DELEGATE

Flores, Jose, M.D., Lic. No. P1754, Houston

On March 4, 2016, the Board and Jose Flores, M.D., entered into an Agreed Order and requiring him to limit his practice, including any office and inpatient practice, to a group or institutional setting approved in advance; have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete at least 24 hours of CME, divided as follows: 12 hours in supervising and delegating to midlevel practitioners, eight hours in ethics and four hours in risk management; within one year and three attempts pass the Medical Jurisprudence Exam; and within 60 days pay an administrative penalty of \$5,000. The Board found Dr. Flores failed to maintain adequate medical records; failed to have standing delegation orders for his midlevel providers; identified several employees as doctors in video advertisements though none were licensed physicians; and aided and abetted the unlicensed practice of medicine by permitting Foreign Medical Graduates (FMGs) to provide prescriptions under his name which constitutes nontherapeutic prescribing of dangerous drugs.

VIOLATION OF BOARD RULES

Husaini, Innad Hasan, M.D., Lic. No. K6006, Cleveland

On March 4, 2016, the Board and Innad Hasan Husaini, M.D., entered into an Agreed Order on Formal Filing restricting Dr. Husaini's practice of medicine solely to the practice of Ophthalmology and Neuro-Ophthalmology. Dr. Husaini shall not prescribe controlled substances and shall not reapply for permission from the DEA/DPS to prescribe controlled substances and shall not engage in the treatment of chronic pain. The Board found Dr. Husaini was involved in the operation of an unregistered pain management clinic. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

VIOLATION OF PRIOR BOARD ORDER

Alsop, Ernest Carson, M.D., Lic. No. J6300, Victoria

On March 4, 2016, the Board and Ernest Carson Alsop, M.D., entered into a Modified Agreed Order on Formal Filing modifying Dr. Alsop's 2011 Order. The modification adds a public reprimand and requires Dr. Alsop to within 60 days pay an administrative penalty of \$1,000. The Board found Dr. Alsop violated the drug testing protocol pursuant to the 2011 Order. All other terms of the order remain in full force and effect. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

Krantz, Jeffrey S., D.O., Lic. No. J7343, Kingwood

On March 4, 2016, the Board and Jeffrey S. Krantz, D.O., entered into a Modified Agreed Order modifying Dr. Krantz's 2014 Order. The modification requires Dr. Krantz to within one year to successfully complete the Professionalism and Problem Based Ethics (CPEP), or a professionalism and ethics course offered by the Vanderbilt Center for Professional Excellence; and within one year complete at least four hours of CME in risk management. The Board found Dr. Krantz failed to pass the CPEP course within one year as required by the 2014 Order. All other terms of the order remain in full force and effect.

Mann, Christopher Rolan, D.O., Lic. No. H2559, Fort Worth

On March 4, 2016, the Board and Christopher Rolan Mann, D.O., entered into an Agreed Order prohibiting Dr. Mann from treating patients for chronic pain as defined in the order; and requiring Dr. Mann to have his practice monitored by

another physician for eight consecutive monitoring cycles. The Board found Dr. Mann violated his 2013 order by continuing to treat one chronic pain patient that he did not refer to a specialist within 30 days as required by the order.

Stafford, Navarro Charles, M.D., Lic. No. H5072, Port Arthur

On March 4, 2016, the Board and Navarro Charles Stafford, M.D., entered into an Agreed Order Modifying Prior Order, modifying Dr. Stafford's 2013 Order. The modification extends the time period by one year for Dr. Stafford to complete all the terms of his 2013 Order. The Board found Dr. Stafford was in violation of his 2013 by failing to timely complete the CME hours set out in the order but the Board panel felt Dr. Stafford had taken steps to comply with the provisions once Dr. Stafford had the financial resources again after a bankruptcy. All other terms of the order remain in full force and effect.

Zawislak, Walter J., M.D., Lic. No. K8596, McAllen

On March 4, 2016, the Board and Walter J. Zawislak, M.D., entered into an Agreed Order requiring Dr. Zawislak to within 60 days contact the TMB Remedial Coaching Program at the University of Texas at Dallas School of Management to determine if the program will accept Dr. Zawislak and, if accepted, complete the program within one year; if not accepted, contact his TMB Compliance Officer within 30 days. The Board found Dr. Zawislak did not follow KSTAR's recommendation that he undergo a brief re-assessment as required by the 2015 Final Order.

INADEQUATE MEDICAL RECORDS

Hayes, Leo Michael, D.O., Lic. No. K2486, Houston

On March 4, 2016, the Board and Leo Michael Hayes, D.O., entered into an Agreed Order requiring Dr. Hayes to have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year complete at least eight hours of CME in risk management; and pay an administrative penalty of \$3,000 within 90 days. The Board found Dr. Hayes failed to use diligence in his practice and failed to maintain adequate medical records for the patients, including documentation that he performed Osteopathic Manipulative Therapy.

Terneny, Orlando Julio, M.D., Lic. No. D7896, Houston

On March 4, 2016, the Board and Orlando Julio Terneny, M.D., entered into an Agreed Order requiring Dr. Terneny to within one year complete at least four hours of CME in medical recordkeeping and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Terneny's medical records for a patient were largely illegible and that he failed to note all pertinent information for the patient's exam.

White, Stephen Curtis, M.D., Lic. No. L3183, Denison

On March 4, 2016, the Board and Stephen Curtis White, M.D., entered into an Agreed Order on Formal Filing requiring Dr. White to within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and within one year complete at least four hours of CME in general fracture management. The Board found Dr. White documented a patient had fracture instability at the first follow-up visit but failed to adequately document that he recommended appropriate treatment. Dr. White's medical records for the patient lacked adequate documentation regarding his treatment recommendations. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

NON-CERTIFIED RADIOLOGIC TECHNICIAN

Mendoza, Felipe, NCT, Cert. No. NC05131, Plano

On March 4, 2016, the Board entered a Final Order against Felipe Mendoza, NCT, which revoked Mr. Mendoza's Texas non-certified radiologic technician certificate. The Board found Mr. Mendoza was adjudged guilty and sentenced to five years in the Texas Department of Criminal Justice, Institutional Division, for the felony offense of manufacture or delivery of a controlled substance in Collin County, Texas. The action was based on the findings of an administrative law judge at

the State Office of Administrative Hearings. This order resolves the formal complaint filed at the State Office of Administrative Hearings. Mr. Mendoza has 20 days from the service of the order to file a motion for rehearing.

CEASE AND DESIST

Carlson, Ky, No License, The Woodlands

On March 4, 2016, the Board and Ky Carlson entered into an Agreed Cease and Desist Order, prohibiting Mr. Carlson from acting as, or holding himself out to be, a licensed physician in the state of Texas. Mr. Carlson shall cease and desist from identifying himself as a doctor, unless he does so in compliance with Healing Arts Identification Act. The Board found Mr. Carlson refers to himself as Dr. Ky or "doctor" in publications without specifying an authority for the use of the title of "Dr." or "doctor." Mr. Carlson's website and other promotional materials state he is licensed by the Pastoral Medical Association. This entity does not confer any authority upon Mr. Carlson to practice medicine in the state of Texas under the Medical Practice Act.

Duncan, Stephan, No License, Plano

On March 4, 2016, the Board and Stephen Duncan entered into an Agreed Cease and Desist Order, prohibiting Mr. Duncan from practicing medicine in the state of Texas. The Board received a complaint that Mr. Duncan engaged in the unlicensed practice of medicine by diagnosing a holistic health client with cancer and anemia and provided natural supplement treatments to the client to treat the condition. In addition the Board became aware of videos depicting Mr. Duncan using the term "Dr." or "Doctor" were still posted online which were the subject of a previous cease and desist order.

Jimenez, Julio, D.C., No License, San Antonio

On March 4, 2016, the Board and Julio Jimenez, D.C., entered into an Agreed Cease and Desist Order, prohibiting Mr. Jimenez from engaging in the unlicensed practice of medicine. Mr. Jimenez shall indicate on each page of his website and other advertising, where the term "doctor" or "Dr." appears, that he is a doctor of chiropractic. In addition, where reference to the Pastoral Medical Association (PMA) appears on his website and other advertising, Mr. Jimenez shall indicate PMA is not a state licensing agency, and he will comply with Tex. Occ. Code 104.004 with respect to the use of the title "doctor" in relation to his "D.PSc" credential. The Board found Mr. Jimenez has published information, including Internet website pages, other postings, and mailings that did not at all times make it clear that his is not a medical doctor. Some of the material that Mr. Jimenez posted and mailed could be read to imply that he treats medical and physical conditions, including chronic conditions of persons.

Lozano, Pedro J., No License, Galveston

On March 4, 2016, the Board and Pedro J. Lozano entered into an Agreed Cease and Desist Order, prohibiting Mr. Lozano from acting as, or holding himself out to be, a licensed physician in the state of Texas. Mr. Lozano shall cease and desist any practice of medicine and desist from identifying himself as a doctor, unless he does so in compliance with Healing Arts Identification Act. The Board found Mr. Lozano refers to himself as Dr. Lozano or "doctor" in publications and online without specifying an authority for the use of the title of "Dr." or "doctor." Mr. Lozano's website and other promotional materials state he is licensed by the Pastoral Medical Association. This entity does not confer any authority upon Mr. Lozano to practice medicine in the state of Texas under the Medical Practice Act.

Madden, John, No License, Cedar Park

On March 4, 2016, the Board and John Madden entered into an Agreed Cease and Desist Order, prohibiting Mr. Madden from acting as, or holding himself out to be, a licensed physician in the state of Texas. Mr. Madden shall cease and desist from identifying himself as a doctor, unless he does so in compliance with Healing Arts Identification Act. The Board found Mr. Madden refers to himself as Dr. Madden or "doctor" in publications without specifying an authority for the use of the title of "Dr." or "doctor." Mr. Madden's website and other promotional materials state he is licensed by the Pastoral Medical Association. This entity does not confer any authority upon Mr. Madden to practice medicine in the state of Texas under the Medical Practice Act.

Merrickh, Kirk, No License, Houston

On March 4, 2016, the Board and Kirk Merrikh entered into an Agreed Cease and Desist Order, requiring Mr. Merrikh to cease and desist from practicing medicine in the state of Texas, including the diagnosing of and prescribing to patients, unless and until he is appropriately licensed. The Board found Mr. Merrikh admitted to consulting with a patient who then received prescriptions without being evaluated by a nurse practitioner or medical director where he was employed.

Strausberg, Stuart E., D.O., No License, Van Nuys, CA

On March 4, 2016, the Board and Stuart E. Strausberg, D.O., entered into an Agreed Cease and Desist Order prohibiting Dr. Strausberg from practicing medicine in the state of Texas without a license issued by the Texas Medical Board. The Board found that Dr. Strausberg was unaware that films he was reading were those of Texas patients. Dr. Strausberg reviewed the films at the request and under contract with an independent transcription service, which provided Dr. Strausberg with the actual films and that did not contain information that identified patients or location. Dr. Strausberg is a California licensed physician, but does not hold a Texas medical license. Dr. Strausberg maintains that he never intended to read films of Texas patients and was unaware he was doing so.

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To view disciplinary orders, visit the TMB website, click on "Look Up A License," accept the usage terms, then type in a licensee's name. Click on the name shown in the search results to view the licensee's full profile. Within that profile is a button that says "View Board Actions."

All releases and bulletins are also available on the TMB website under the "Newsroom" heading.